children. Furthermore, our proposal would increase the widow's benefit to 75 percent of the combined benefits that a husband and wife would be entitled to based on their own earnings.

Congressional Republicans and Democrats and the administration all have established saving Social Security as a top priority. Now we must move ahead with the process and provide leadership. Each year that we wait to enact legislation to save Social Security, the changes must be more pronounced to make up for the lost time. I urge my colleagues to cosponsor the Bipartisan Social Security Reform Act.

The PRESIDING OFFICER. The Senator from Florida is under a previous order to speak for up to 10 minutes.

Mr. DOMENICI. Parliamentary inquiry. Is there any order subsequent to that?

The PRESIDING OFFICER. Yes. The Senator from New Mexico will be recognized, following the Senator from Florida, for up to 10 minutes.

Mr. DOMENICI. I thank the Chair.

The PRESIDING OFFICER. The Senator from Florida is recognized for 10 minutes.

Mr. DORGAN. Mr. President, I ask unanimous consent to follow the Senator from New Mexico.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senator from Florida.

PATIENTS' BILL OF RIGHTS

Mr. GRAHAM. Mr. President, I come to the floor to voice my strong objection to hidden provisions which were inserted in the so-called last amendment during the consideration of the HMO Patients' Bill of Rights.

Last night, at approximately 8 o'clock, an amendment was offered which had over 250 pages. It had been represented throughout the debate that this amendment would be of a corrective, technical nature. There were several statements made on the floor that alterations, which had been agreed to verbally, would be incorporated in that final amendment. What we find is that quite a different thing has occurred.

First, I have found that several of the areas in which I had clear representations that refinements would be made were not made. In the area, for instance, of the emergency room, one of the key issues we spent considerable time debating had to do with poststabilization coverage. It was my understanding we had arrived at an agreement as to how to correct the language which all parties had appeared to agree would be an undue restriction on the rights of patients to receive proper care in an emergency room. I am sad to have to report that those changes were not incorporated in the final version of the legislation.

I am even more offended by the fact that while the changes we thought would be there were, at least in this instance, not obtained, but more so there were extraneous issues inserted, issues that had never been considered on the floor, never considered by a committee, never debated and unknown until they were unearthed, in the case of the issue I was to raise on page 252 and 253 of the so-called manager's amendment.

What is the provision I am so concerned about? It is section 901, ''Medicare Competitive Pricing Demonstration Project.'' If you want to get the full flavor of this, let me just quote:

(a) FINDING.—The Senate finds that implementing competitive pricing in the medicare program . . . of the Social Security Act is an important goal.

I could not agree more with that statement. So that would cause your heart to beat, your level of anticipation to be excited as you want to go on to what is the next paragraph that will implement that goal.

What is the next paragraph? It says: Notwithstanding what has been said above, the Secretary of Health and Human Services may not implement the Medicare demonstration project on competitive bidding; and, furthermore, notwithstanding any other provision, the Secretary of Health and Human Services may not implement any other competitive pricing project before January 1, 2001.

An absolute outrage.

Let me give you a little history of this.

When the Medicare program began to move beyond fee for service and to accept modern ways of health care, it did so in a rather cumbersome way. It said that we will reimburse a health maintenance organization on a formula; and the formula is 95 percent of the fee for service payments to Medicare beneficiaries within that community.

That may have some superficial rationale, but let me tell you what really happens.

First, if you happen to be in a community that has, for instance, a large teaching hospital or other complex medical center that serves a larger region, you are going to have high fee-for-service payments because of the nature of the health care that is delivered in that community. I would imagine that Rochester, MN, is a community that has relatively high fee for service because it has that great Mayo Clinic. I can tell you that Miami, FL, has high fee-for-service charges because it has a number of tertiary care hospitals. So because of that aberration that has nothing to do with what an HMO should be reimbursed, HMOs in those communities get 95 percent of fee for service.

There were some modifications made of that in the 1997 Balanced Budget Act, but the basic principle of a formula-based reimbursement which relates back to fee for service is still largely in place.

There is a second sequence of that in that we have very erratic fee levels for HMOs. The community that is immediately adjacent to the high fee-for-service community can have very low fee-for-service medicine delivered there, and therefore the HMOs get a much lower fee.

In my State, the differential from the highest to the lowest community is probably on the order of at least 100 percent from the highest to the lowest community that has an HMO program.

What is the consequence of that? The consequence of that is reported in today's Washington Post on page A–2. I ask unanimous consent to have that article printed in the RECORD immediately following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

(See Exhibit 1.)

Mr. GRAHAM. It states: ''HMOs Will Drop 327,000 Medicare Beneficiaries Next Year.''

We have just spent 4 days of debate on trying to avoid having people dropped from their HMOs, and we now have an announcement that just in the Medicare program alone—the Medicare program has 39 million participants, and approximately 4 million of those are in HMOs—out of that relatively small number of HMO beneficiaries, 327,000 are being dropped.

What does it say? It says that of those who are being dropped, 79,000 will be unable to enroll in another HMO because there are no other HMOs in their area.

When the industry was asked, why is this happening, their answer was: The managed care industry says HMOs are pulling out of Medicare because the Government isn't paying them enough.

You would think the industry would therefore want to have an alternative system that would provide adequate reimbursement, but not excessive reimbursement, and that the place to achieve that is the marketplace.

We heard a lot of talk this week about how we ought to have deference to the marketplace. I think what the HMOs want is to have free enterprise when it relates to service to the patients, and they want to have socialism when it relates to how much revenue they get paid.

So in 1997, in the face of all of these factors, the Congress, by a very strong vote—I think it was 76 votes in the Senate—passed the Balanced Budget Act which contained a provision that would actually start HMOs toward a competitive bidding process—the same process, incidentally, used by many other large HMO users, State and local governments, and in the private sector.

It was started very modestly, with a demonstration plan so that we could learn about what was involved in competitive bidding for HMOs. I, frankly, thought that was excessive caution, that we could have taken advantage of

the experience that was already available by many other large users, but the thought was, let's go slow, let's do a demonstration project.

So since 1997, HCFA, the Federal agency with responsibility for managing Medicare, has been organizing this demonstration project. They selected Kansas City and Phoenix as the two sites for the demonstration project. They are about to start, and all of a sudden, on the 252nd page of what is supposed to be a corrective manager's amendment, we not only bar the demonstration projects that are about to commence but bar any other demonstration projects that may be suggested. Yet we started with a finding that we support competitive bidding.

Boy, I tell you, if this is the way they support the principle, you do not want them to be your parents and say they are going to give you good care.

Mr. DORGAN. Will the Senator yield for a short question?

Mr. GRAHAM. Mr. President, I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. The Senator has 28 seconds remaining.

Mr. GRAHAM. I ask unanimous consent for an additional 5 minutes.

The PRESIDING OFFICER. If there is no objection.

Without objection, it is so ordered.

Mr. DORGAN. I want to inquire. I was unaware that that provision was in the package that was presented. Was the Senator from Florida aware, did he know of anyone else who was aware of that except perhaps the folks who wrote it?

Mr. GRAHAM. We have not found anybody who was aware of it except some diligent soul who actually got to page 252 of the bill sometime late last night or this morning and discovered this. I might say, it is very difficult to even get copies of this amendment.

We have known for several years that the HMO industry did not want competitive bidding. They like the socialized formula system that exists today. They are attempting in any way they can, including this stealth attack late last night on page 252, to kill competitive bidding.

Unfortunately, just as with the issue of the HMO bill we have been debating, on the issue of patients versus the bottom line of the HMOs, the HMOs won in the Patients' Bill of Rights, and they have won again by killing competitive bidding. I say they have won. I think it is a Pyrrhic victory.

I think the Senator from North Dakota might recall an event that, as Yogi Berra said, it is deja vu all over again. I think it was just about 3 years ago, in a similar stealth maneuver, that we discovered there was embedded in a large bill a provision that would have given the tobacco industry a $50 billion tax break. Once that issue surfaced, it could not stand the light of day. It slowly withered, died, and has not been resurrected.

I suggest the light of day will be shed on what the HMO industry has done by inserting this amendment on page 252 of a technical amendment, the fact they are using this as a means of avoiding the rigors of the marketplace, they are using this to avoid a rationalization of the compensation that HMOs receive from their patients so that we don't continue this pattern of 32,700 people being dropped. I can tell my colleagues, most of these people are people who come from rural areas. They come from small towns where they don't have high fee-for-service medicine. The HMOs want to skim off those areas that have high fee-for-service, where they can get a formula that results in a very rushed reimbursement level. They don't want to provide services, and they don't even want to have a competitive bidding process that can arrive at what the marketplace says they should be paying for those HMO beneficiaries in smaller communities of America.

What we are seeing, again, is the bottom line winning out over the rights, the interests, and the health of patients. We are watching as Medicare patients are dumped on the street. Is that the HMO industry's idea of reform? It is my idea of a travesty, and it is one that we need to bring to the attention of America. And we, as the Senate, need to expunge this dark page, page 252, and its companion, page 253, from our records. I hope we will, at the first opportunity, do so.

I thank the Chair.

EXHIBIT 1

[From the Washington Post, July 16, 1999]

HMOs WILL DROP 327,000 MEDICARE BENEFICIARIES NEXT YEAR

(By David S. Hilzenrath)

About 327,000 of the 6.2 million Medicare beneficiaries nationwide who belong to HMOs will be abandoned by their health plans next year, the government said yesterday.

Of those, 79,000 will be unable to enroll in another health maintenance organization as 41 health plans withdraw from the federal health insurance program for the elderly and disabled and another 58 stop serving Medicare beneficiaries in particular areas, according to the agency that runs Medicare.

Medicare beneficiaries who lose their HMO coverage have two or three alternatives: They can choose another HMO, if one is available; they can revert to standard fee-for-service Medicare coverage; and they can buy ''Medigap'' policies to supplement the standard benefits.

But there is no guarantee that they can find a Medigap policy with prescription drug coverage, which is one of the main reasons some Medicare beneficiaries choose HMOs.

In Maryland and Virginia, 33,000 beneficiaries—26.9 percent of those with HMO coveage—will lose their current coverage, and 27,000 will be unable to replace it with another HMO.

An HMO industry group recently predicted that more than 250,000 beneficiaries would be affected by the changes, but the Department of Health and Human Services released the final tally based on notices HMOs were required to submit by July 1.

This year, a larger number of beneficiaries—407,000—were abandoned by their HMOs, but a smaller number—51,000—were left without an HMO option.

The managed-care industry says HMOs are pulling out of Medicare because the government isn't paying them enough, but the government says the HMOs' actions reflect broader industry trends.

THE NON-SOCIAL SECURITY SURPLUS

Mr. DOMENICI. Mr. President, I will take a little time to speak about the surplus that we have over and above Social Security, which we call the non-Social Security surplus. That is the amount by which the taxpayers of this country have paid more into the U.S. Treasury than we need to run Government.

I choose now to speak to a proposal that I made with the introduction of a tax bill yesterday. I introduced it and had it printed and reported to the appropriate committee because I thought that even though I am not on the Finance Committee, that some of my ideas and thoughts might be relevant. I wanted the Senate to have the benefit of what I thought should be a good way to fix the Tax Code while we are reducing taxes.

Let me address this matter in a text that I have prepared and worked very hard on, including the bill that was introduced. I thank my staff for the diligent work and the Joint Committee on Taxation for their willingness to help us with evaluations of how much these various proposals will cost.

T.S. Eliot wrote, ''April is the Cruelest Month.'' Millions of Americans agree, especially around April 15. The Congress is going to pass a tax bill to make April a little kinder. I say it is time to share the surplus. Since without tax relief it takes the average worker until May 11 to earn enough money to pay his or her taxes, our tax bill also lets people start working for their families' benefit earlier in the year.

American families are currently saddled with an unprecedented tax burden. Total Federal tax collections are at a post-World War II high of 20.7 percent of the gross domestic product. Individual income tax collections alone are 10 percent of the gross domestic product and are projected to stay there. We have never experienced a government based on that level of income taxation, speaking of the income tax component of our total American government tax table.

The 1990s are truly a decade when government taxed the total population of America at a very excessive rate. The President will have a choice to spend on government programs or resist the urge to splurge and instead return the overpayment to its rightful